ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS

*payment***basics**

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Accountable care organizations (ACOs) are groups of health care providers that have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. The goals for ACOs are to improve coordination and quality of care, maintain beneficiary choice of provider, and reduce unnecessary services. Beneficiaries do not enroll in ACOs; instead, Medicare attributes beneficiaries to ACOs based on their Medicare claims history.[1] The beneficiary is still free to use providers outside of the ACO. Providers both inside and outside the ACO generally continue to be paid their normal fee-for-service (FFS) rates by Medicare. If attributed beneficiaries choose to go to a provider outside of the ACO, the ACO remains responsible for this spending. This creates an incentive for the ACO providers to satisfy their patients and keep them in the ACO. Medicare provides ACOs with claims data for attributed beneficiaries to help the ACOs coordinate care. This design avoids some of the overhead costs associated with Medicare Advantage (MA) plans, such as marketing, enrollment, creating networks, and paying claims.

There are currently three different Medicare ACO programs. The Medicare Shared Savings Program (MSSP) is a permanent part of the Medicare program. It was created by the Patient Protection and Affordable Care Act of 2010 (PPACA) and became operational in 2012. The program has 480 ACOs serving 9.0 million beneficiaries.

The second is the Next Generation ACO demonstration, which started in 2016 and now has 44 ACOs participating. It incorporates higher levels of risk and reward than MSSP and also includes a small financial incentive for beneficiaries to use ACO providers. Spending targets are set differently so that they are more predictable and include a discount.

The third ACO program is the Medicare ACO Track 1+ model. It will begin in 2018. It is similar to the basic MSSP program, but it includes prospective attribution and introduces some downside risk. It is primarily designed for smaller ACOs that may have an aversion to high risk but want to enable their clinicians to qualify for the advanced alternative payment model incentive in the Medicare Access and CHIP Reauthorization Act of 2015.

CMS reports MSSP ACOs have formed in all 50 states; Washington, DC; and Puerto Rico. Most ACOs serve urban areas; only 12 percent serve predominantly rural and other low-population-density areas. Although the largest number of ACOs is in the South, the Northeast has the highest proportion of Medicare beneficiaries in ACOs.

What are ACOs accountable for?

Medicare ACOs are accountable for the total Medicare Part A and Part B spending for a defined population of beneficiaries and for the quality of their care.

Who can form an ACO?

ACOs are groups of providers such as physicians and hospitals. The group must include primary care providers because beneficiaries are attributed to ACOs based on their use of primary care services. Other providers such as specialists and hospitals can be included but are not strictly necessary. Unlike MA plans, ACOs do not need to have a network that provides all Medicare services. This is because Medicare beneficiaries who are attributed to ACOs can, like any other FFS beneficiary, go to any provider who accepts Medicare. Beneficiaries are not "locked in" to the ACO.

Payment mechanics

When an ACO applies to the program, it specifies the providers in the ACO.

This document does not reflect proposed legislation or regulatory actions.

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Medicare then determines which beneficiaries received the plurality of their primary care from the providers in the ACO in the 'baseline' time period.[2] Those beneficiaries are then attributed to the ACO. Once the attributed beneficiaries are identified, CMS then computes the Part A and Part B spending (the "benchmark") for the beneficiaries during the baseline period. In the MSSP program, that baseline period is three years, and the spending is averaged over those three years with the most current expenditures given more weight.[3]

To determine the benchmark (or expected) expenditure amount for the ACO, the baseline expenditures are trended forward using trends in FFS spending. At the end of the year, actual expenditures for attributed beneficiaries are compared with the expected expenditures, and savings or losses are computed. If there are savings (that is, actual expenditures are less than expected), those savings are shared between the Medicare program and the ACO. If there are losses (that is, actual expenditures are greater than expected), those losses may be shared between the program and the ACO if the ACO has chosen to share risk with the program—a two-sided risk arrangement. (Losses are not shared under a one-sided risk arrangement.) Ninety-one percent of MSSP ACOs have chosen to be in a one-sided risk arrangement. Quality also enters into the calculation of shared savings and losses. Essentially, the higher the quality, the greater share of the savings the ACO receives (and the smaller the share of the losses in a two-sided risk arrangement). In the MSSP, this process is repeated each year of the three-year contract, and then the ACO baseline is rebased to start another contract period.

In the MSSP program, the actual shared savings rates and other parameters can vary depending upon which of the three payment tracks an ACO chooses. Track 1 and Track 2 have been in effect since the program started in 2012. Track 3 started in 2016. Table 1 displays the options.

Table 1 Parameters for the MSSP ACOs

Parameter	Track 1	Track 2	Track 3
Risk	One-sided	Two-sided	Two-sided
Minimum number of beneficiaries	5,000	5,000	5,000
Shared savings rate	50%	60%	75%
Performance payment limit	10%	15%	20%
Minimum savings rate (MSR)	Ranges from 2.0 to 3.9%*	Several options**	Several options**
ACOs in 2017	438	6	36
Shared loss rate	N/A	1 minus final shared savings rate***	1 minus final shared savings rate, but not less than 40%
Loss sharing limit	N/A	5% in year 1 7.5% in year 2 10% in year 3 and after	15%

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).
*MSR varies inversely with attributed population, from 2.0% for an ACO with 60,000 or more beneficiaries to 3.9% for ACOs with 5,000 beneficiaries.
**Option 1: no MSR; Option 2: MSR ranges from 0.5 to 2.0%; Option 3: as in Track 1
***The final shared savings rate = shared savings rate × quality score.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2016. Medicare Shared Savings Program ACO final rule. *Federal Register* 81, no. 110. January 2017 Medicare Shared Savings Program fast facts.

Almost all MSSP ACOs were in Track 1 in 2017. ACOs are now allowed to be in Track 1 for two three-year agreement periods. They will then have to transition to a two-sided risk arrangement, either Track 2 or Track 3 or to the Track 1+ model.

ACOs in the Next Generation demonstration have two-sided risk and can have shared savings rates up to 100 percent. ACOs in the Track 1+ model will have a shared savings rate of 50 percent and a shared loss rate of 30 percent.

Risk adjustment—MSSP and NextGen take into account the changing health status of an ACO's population. The MSSP differentiates between continuously assigned beneficiaries and newly assigned beneficiaries. The hierarchical condition category (HCC) risk scores of the newly assigned beneficiaries are assessed, and if their average is different from the average HCC score of the ACO's original population, the benchmark is adjusted (e.g., if the newly attributed beneficiaries' average risk score were higher than the historical population's risk score, the trend for the benchmark would be adjusted up). The average risk score of the continuously assigned population is also assessed. It can decrease or it can increase; however, it is only allowed to increase as much as a population with similar demographics.

Quality—CMS measures ACOs' quality in four domains:

- Patient/caregiver experience: 8 measures (16 possible points)
- Care coordination/patient safety: 10 measures (22 possible points; electronic health record measure is worth 4 points)
- Preventive health: 8 measures (16 possible points)
- At-risk populations: 5 measures (8 possible points; the diabetes measure is a composite of 2 measures)

The total number of points earned in a domain is divided by the maximum possible number of points, generating a domain score. Each domain score is weighted at 25 percent of the total quality score. The total quality score is multiplied by the shared savings rate to find the final shared savings rate. That rate is used to determine the amount of shared savings the ACO receives if the ACO achieves shared savings. In two-sided risk models, the final shared loss rate is one minus the final shared savings rate (with some limits), which means the higher the quality score, the lower the shared loss rate.

Quality benchmarks are computed using Medicare claims data, data from the Physician Quality Reporting System (PQRS), quality data reported by ACOs, and quality data collected from the larger Medicare FFS population. ACOs can score additional points for significant quality improvement (in contrast to attaining specified levels of performance), up to four points in each domain. However, the total points earned cannot exceed the maximum number of points possible in the domain.

Results to date

CMS reports that the MSSP has shown modest success. CMS reported that MSSP ACOs had better results than FFS on many of the quality measures for which comparable results were available and that ACOs in the program in 2014 and 2015 showed improvement in their performance on quality measures over time.

CMS reports that some ACOs have achieved modest reductions in spending relative to their benchmarks. The reductions to date are often concentrated in ACOs in areas with high service use. Table 2 summarizes the 2015 financial results of the MSSP.

However, taking into account bonus payments paid to ACOs, Medicare spent $216 million more on the MSSP in 2015 than estimated by the benchmarks. This is because almost all MSSP ACOs are in one-sided "bonus-only" models. Thus, even though in aggregate benchmarks exceeded actual expenditures by $429 million, Medicare paid out $646 million in shared savings to the ACOs that had shared savings and did not collect anything from the ACOs that had losses.

Table 2 Summary financial results for Medicare Shared Savings Program, 2015

	Millions of dollars	Percent
Benchmark	$73,298	100.0%
Actual spending	72,868	99.4
Difference	429	0.6
Paid to ACO	646	0.9
Returned to CMS	0	0.0
Net	–216	–0.3

Note: ACO (accountable care organization). Data represent the performance of 392 ACOs. Components may not sum to totals due to rounding.

Source: CMS data on 2015 ACO performance, August 2016.

Benchmarks are designed to reflect policy goals. Benchmarks do not necessarily represent the true counterfactual (i.e., what spending would have been in the absence of the ACO). Estimates of the counterfactual should take into account factors such as relevant trends in spending and the relationship between attribution and service use.

In contrast, the Pioneer ACO demonstration (which was the predecessor to the Next Generation ACO demonstration) had a small net reduction in spending relative to its benchmarks of under 1 percent in 2015. (This calculation takes into account payments to ACOs for shared savings and payments from ACOs to CMS for shared losses.) In April of 2015, the CMS Actuary certified that expansion of the Pioneer demonstration would reduce net program spending.[4] CMS also reported that, overall, Pioneer ACOs achieved good quality metrics compared with traditional FFS providers for quality measures for which comparable results were available and that quality scores have improved over the life of the program. ■

1 Medicare is beginning to allow beneficiaries to choose their "main doctor" and attribute those beneficiaries to ACOs on that basis. Few have done so to date.

2 *Plurality of primary care* is defined as an ACO's practitioners providing the plurality of certain qualified evaluation and management services measured by charges for those services.

3 When resetting the benchmarks for subsequent three-year agreements, baseline years are weighted evenly, and regional expenditures will be factored in as well.

4 Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015. Memo: Certification of Pioneer model savings. April 10.